BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross Blue Shield Association.

Prior Authorization

Frequently Asked Questions

1. **How can I complete a prior authorization request for two or more procedures via My Insurance Manager℠?**
   You cannot complete a prior authorization request for more than one service on a single entry using My Insurance Manager℠. Once you have chosen your request type and select one service, you will continue through the remaining prior authorization request screens to completion. At that time, you may begin a second request.
2. **What is a dollar threshold for durable medical equipment (DME)?**
   Prior authorization requirements for DME can vary per plan. For this reason, it is important to verify eligibility and benefits.
3. **How can I check authorization requirements for out-of-state members?**
   To check authorization requirements for out-of-state members, you can use the BlueCard® Prior Authorization Lookup Tool located on www.SouthCarolinaBlues.com or by calling the BlueCard® eligibility line at 800-676-BLUE (2583).
4. **What methods can be used to obtain prior authorization?**
   - Authorizations can be requested using one of the following avenues:
   - My Insurance Manager℠*
   - Medical Forms Resource Center (MFRC)*
   - Fax
   - Phone

   ** Preferred methods.*
5. **What information is required when requesting prior authorization?**
   When requesting prior authorization, the following information should be included:
   - Patient details – Name, ID Number, and Date of Birth
   - Service details – CPT/HCPCs codes with correct units, diagnosis codes, and MD orders
   - Location details – Name of facility and rendering physician, address, and Tax ID/NPI
   - Contact details – Call back number and fax number
   - Date of service
   - Clinical documentation – Including how long the problem has been occurring, attempted treatments, conservative medications, studies (e.g., labs, imaging, assessments, etc.
6. **What are the guidelines for authorizations?**
   The general guidelines for authorizations include:
   - Submit elective requests prior to rendering services
   - Submit requests once and allow time for review

- Services must be covered under the member's plan
- Member must have active coverage at the time of request
- Submit a notification of emergency admission within 24 to 48 hours of admission
- Mark requests as urgent ONLY when they are urgent

7. **What can I do if an authorization request is denied?**

   If an authorization is denied, you can request an appeal or a peer-to-peer review. Peer-to-peer reviews are available if:

   - A medical necessity adverse decision was received, along with health plan denial
   - Requested within two business days of the denial for inpatient or continued stay requests or five days for all other denials
   - Requested prior to an appeal

8. **What third party vendors are used for authorizations?**

   The third-party vendors that manage authorization for certain benefits and plans include:

   - NIA Magellan
   - Avalon Healthcare Solutions
   - MBMNow
   - Companion Benefit Alternatives (CBA)